IMPORTANT INFORMATION FOR HEALTH INSURANCE ISSUERS PARTICIPATING IN THE HEALTHY MICHIGAN MARKETPLACE OPTION PROGRAM FOR 2018

Dear Issuer,

Certain beneficiaries of Michigan's Medicaid expansion program, the Healthy Michigan Plan, must obtain health care coverage through a Qualified Health Plan (QHP) offered on the Marketplace beginning April 1, 2018. As a licensed Health Insurance Insurer in Michigan, you are eligible to participate if you meet the requirements outlined in this email.

Please review the attached documentation, "Guidance for Insurance Issuers" and "Issuer Responsibilities" which will provide you with the following:

- How to participate in the Healthy Michigan Marketplace Option Program
- MDHHS and DIFS specific requirements
- Enrollee eligibility

In the near future, you will be asked to complete a survey as to your interest in participating in this program.

This program is administered by both the Department of Insurance and Financial Services (DIFS) and the Department of Health and Human Services (MDHHS). If you have any questions, we have provided department contacts by topic for your convenience.

Healthy Michigan Plan Marketplace Option

Guidance for Insurance Issuers

I. Overview

As required by Section 105d(20) of PA 107 and the Section 1115 Demonstration Amendment approved by the Centers for Medicare and Medicaid Services (CMS), certain beneficiaries of Michigan's Medicaid expansion program, the Healthy Michigan Plan (HMP), must obtain health care coverage through a Qualified Health Plan (QHP) offered on the Marketplace beginning April 1, 2018. Issuers will be approved by the Michigan Department of Insurance and Financial Services (DIFS) and will agree to participate in this Healthy Michigan Plan Marketplace Option through a Memorandum of Understanding (MOU) entered into with the Michigan Department of Health and Human Services (MDHHS) specifying the financial terms, data sharing and other issuer requirements. Pricing of the Marketplace product will be considered before MDHHS signs and executes an MOU.

II. Eligible Enrollees

Healthy Michigan Plan beneficiaries who have incomes above 100% of the Federal Poverty Level (FPL) and have not completed the healthy behavior requirements in the previous 12 months as required by PA 107 and outlined in the CMS-approved Healthy Behaviors Protocol, must transition to the Marketplace Option, absent an applicable exception. MDHHS will use information from the state's Medicaid eligibility system to determine a beneficiary's income and will assess healthy behavior completion status in accordance with the CMS-approved Healthy Behavior Protocol before advising the beneficiary that they must transition to the Marketplace Option. Individuals who meet the exclusion criteria, those with incomes above 100% of the FPL, and who have met with the Healthy Behavior requirements will also be given a choice of transitioning to the Marketplace Option.

Marketplace Option exclusions include those beneficiaries meeting the medically frail definition (Exhibit A) in accordance with 42 CFR 440.315. Additionally, those who are exempt from cost-sharing pursuant to 42 CFR 447.56 are excluded from the Marketplace Option and will remain in the Healthy Michigan Plan. This includes but is not limited to, pregnant women and children under 21.

III. Enrollment

MDHHS will identify and notify Healthy Michigan Plan beneficiaries who meet the criteria for enrollment in the Marketplace Option and will provide instructions regarding QHP selection, including the right of MDHHS to auto-assign individuals if a plan is not selected in the specified period of time. Auto-assignment will be handled in accordance with a methodology approved by MDHHS and CMS.

MDHHS will utilize an enrollment broker to facilitate this population's enrollment in the Marketplace Option Plans. Issuers will be required to submit provider files using standard transaction 4275 file formatting to the MDHHS enrollment broker to assist beneficiaries in plan selection. After an individual selects or is auto-assigned to a QHP, MDHHS will submit enrollee information to the issuer using an 834 transaction. Upon receipt of this information, the issuer will send an enrollment/welcome packet to the individual, which will include the QHP benefit card, handbook and other relevant coverage information. Reconciliation of

enrollees between MDHHS and the QHP will occur at least monthly, using a process agreed to by MDHHS and the issuer.

Once an individual is enrolled in the Marketplace Option, he or she will remain there for a period of 12 months unless he or she loses Medicaid eligibility, is determined medically frail or becomes eligible for another health care coverage program administered by MDHHS. A medical exception process will be utilized to assess medical frailty during the lock-in period. If an enrollee experiences an income drop to 100% of the FPL or lower or becomes exempt from cost-sharing, he or she will remain in the Marketplace Option until the end of the enrollment period but will not be charged enrollee cost-sharing.

IV. Issuer Participation

Any issuer licensed to write health insurance in the state of Michigan may apply to participate in the Marketplace Option program. No prior Medicaid experience is needed. As the Marketplace Option requires HMP beneficiaries to be enrolled in the individual Marketplace, issuers must apply and be approved by DIFS to participate in Michigan's individual health insurance marketplace. In addition, issuers must sign an MOU with MDHHS specifying the financial terms, data sharing and other issuer requirements.

V. QHP Plan Design

a. General

Participating issuers will designate one or more Silver Level QHPs to facilitate enrollment of Healthy Michigan Plan beneficiaries. The designated Silver Level plans will utilize two of the Marketplace Silver Level cost-sharing variants: (1) 94% AV Silver Level Plan and (2) Zero Cost-Sharing Silver Level Plan. HMP beneficiaries will be initially enrolled in the 94% AV Silver Level Plan unless otherwise eligible for zero cost-sharing. The Zero Cost-Sharing Silver Level Plan will be available to eligible American Indian beneficiaries and will serve to transition HMP beneficiaries who become exempt from cost-sharing after enrollment, as described in the Enrollment section.

b. Benefits, Network Adequacy, Service Areas

The HMP QHPs will provide Essential Health Benefits in accordance with Michigan's 2017 Benchmark Plan. Non-EHB benefits will be provided through a separate wrap benefit by MDHHS (see "Wrap Benefit" section for details). As Marketplace plans, the HMP QHPs will need to meet network and service area requirements as stated in DIFS' Michigan Network Adequacy Guidance, including all Essential Community Provider requirements specified by CMS.

c. Wrap Benefit

MDHHS will cover wrap-around services as required by the CMS Special Terms and Conditions, as follows: Non-Emergency Medical Transportation, Family Planning services provided by non-contracted providers, and health care services obtained at Federally Qualified Health Centers and Rural Health Centers when one is not available through the QHP. MDHHS will provide

Marketplace Option enrollees with the information on how to access covered services outside of the QHP.

VI. MDHHS Premiums, Deductibles and Cost-sharing Reductions

MDHHS will pay to issuers the full cost of plan premium, any applicable deductibles, and cost-sharing reductions. For both the 94% AV and Zero Cost-Sharing plans, MDHHS will pay the enrollee's monthly premium and advanced cost-sharing reduction payment, determined using CMS' cost-sharing reduction methodology. In addition, for the 94% AV plan, MDHHS will advance the full deductible with the first monthly payment. At the end of the year, the issuer will refund any unused deductible payment and reconcile cost-sharing reduction payments using the standard method as outlined in 45 CFR 156.430(b)(2). This reconciliation will not include copayments which are the responsibility of health care providers to collect, except to the extent the maximum copayment has been reached. Payments will be made from MDHHS to issuers using established Marketplace structures.

VII. Enrollee Cost-sharing

a. Enrollee Contributions

Individuals enrolled in the Marketplace Option will be responsible for contributing to the cost of their coverage. Enrollee contributions will be charged monthly and will not exceed 2% of income. Enrollee contributions will be collected by a vendor contracted by MDHHS. If a Healthy Michigan Plan Marketplace Option enrollee participates in a Healthy Behavior that meets the MDHHS requirements, his or her contributions will be reduced by 50% for the remainder of their enrollment in the QHP and will be permitted to return to the Healthy Michigan Plan at the end of the enrollment period.

b. Enrollee Copayments

Marketplace Option enrollees will be subject to QHP-determined copayments at the point of service. Total cost-sharing (enrollee premiums and copayments) incurred by Marketplace Option enrollees is limited in accordance with 42 CFR 447.56(f) and must not exceed 5% of family income per quarter. MDHHS will provide the issuers with a maximum amount of copayments that can be collected at the point of service per quarter for each enrollee in this regard. Issuers will be required, through the MOU, to monitor the copayment charges and suspend copayments when the maximum cost-sharing has been reached so that no further copayments will be charged during that quarter. Marketplace Option enrollees will not lose coverage due to failure to pay copayments.

VI. Appeals

Appeals related to benefits and services provided by an issuer are governed by DIFS. Marketplace Option enrollees will have the same rights to internal and external review as any other individual enrolled in the QHP under the Insurance Code and the Patient's Right to Independent Review Act, MCL 500.100 *et seq.* and MCL 550.1901 *et seq*. In addition, Marketplace Option enrollees will have access to a fair hearing through the MDHHS for actions taken with respect to eligibility or MDHHS covered benefits, consistent with 42 CFR 431. MDHHS will notify Marketplace Option enrollees about these rights as part of the transition process. Additional obligations of the issuers with respect to grievance and appeal processes for Marketplace Option enrollees may be set forth in the MOU between MDHHS and the participating issuers.

Please direct any questions regarding this document to the Department contact:

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EXHIBIT A —Medically Frail and the Healthy Michigan Plan: Executive Summary

Section I: Defining the Medically Frail

The recommended Healthy Michigan Plan definition of medical frailty builds upon the federal guidance and the Healthy Michigan Plan chronic condition list developed for cost-sharing exemptions. The Medical Services Administration (MSA) utilized a three-pronged approach to identify the medically frail: (1) Self-Identification via the Application for Health Coverage & Help Paying Costs (Question #14 of DCH-1426), (2) Retrospective Claims Analysis, and (3) Provider Referral. Below are details for each:

1) Self-Identification via Application for Health Coverage & Help Paying Costs (DCH-1426 Question #14) or other Self-Attestation Process approved by MDHHS
   - Most efficient way to capture medically frail information
   - Limited in that it only represents 11.8% of the identified medically frail (3,118 beneficiaries)

2) Retrospective Claims Analysis
   Factors in data that will identify medically frail conditions, including:
   - MSA-chosen ICD-10 diagnosis codes (over 2,600 codes identified)
   - A Prepaid Inpatient Health Plan (PIHP) relationship (two or more PIHP encounters within the past year)
   - Whether a beneficiary is in a nursing home, hospice or Children's Special Health Care Services (CSHCS)

3) Provider Referral
   - Allows providers to recommend to MDHHS that a beneficiary be considered medically frail through clinical judgment.

Section II: Estimating the Medically Frail and Marketplace-Projected Populations

Table 1: Select Data of the Marketplace-eligible HMP Population		
	# of Marketplace-eligible HMP Population	**% of Marketplace-eligible HMP Population**
Total Marketplace-eligible HMP Population[1]	79,114	100.0%
Unduplicated Medically-Frail Population	**26,481**	**33.5%**
HRA Completion for Non-Medically Frail Population	1,489	1.9%
Subtotal No Marketplace (Med frail + HRA comp)	*27,970*	*35.4%*
Estimated Marketplace-subjected Population	51,144	64.6%

[1]The 79,114 excludes FFS beneficiaries of the over 100% FPL HMP Population

Table 2: Breakdown of the Medically Frail Population		
	# of Medically Frail Population	% of Medically Frail Population
Unduplicated Medically-Frail Population	**26,481**	**100%**
Unduplicated ICD-10 Codes	22,702	85.7%
Unduplicated Nursing Home Beneficiaries	0	0.0%
Unduplicated Hospice Beneficiaries	0	0.0%
Unduplicated CSHCS Beneficiaries	0	0.0%
Unduplicated MAGI Application Check-Yes	3,118	11.8%
Unduplicated PIHP Relationship	661	2.5%

Healthy Michigan Plan Marketplace Option

Issuer Responsibilities

This document summarizes the proposed responsibilities of Issuers in providing coverage to Healthy Michigan Plan Marketplace Option enrollees.

Topic	Issuer Proposed Requirements	Department Contact
Issuer Participation	• An Issuer licensed to write health insurance in the state of Michigan may apply to participate in the Marketplace Option program for the 2018 plan year. • Apply and be approved by DIFS to participate in the Marketplace. • Must meet all timelines and requirements as stated in the DIFS BULLETIN-"2018 Form and Rate Filing Requirements for Medical Plans" (release date March 2017).	Laurie VanBeelen, DIFS
Plan Details	Must be filed as a Silver Level plan with at least two cost-sharing variants • Plan 1-94% AV Level Plan. • Plan 2-Zero Cost-Sharing Level Plan. (This plan is available to eligible American Indian beneficiaries and will serve to transition HMP beneficiaries who become exempt from cost-sharing after enrollment.)	Laurie VanBeelen, DIFS
Benefits, Network Adequacy and Service Areas	• Cover the Essential Health Benefits (EHBs) as stated in the Michigan 2017 Benchmark Plan. • Meet Networks and Service Area requirements as stated in DIFS' Michigan Network Adequacy Guidance. • Meet all Essential Community Provider requirements as required by ACA requirements and CMS.	Laurie VanBeelen, DIFS

Topic	Issuer Proposed Requirements	Department Contact
Enrollment and Disenrollment	• Accept enrollment and disenrollment information from MDHHS and/or its enrollment broker. ➢ Enrollment and disenrollment will occur outside of the open enrollment period. ➢ Enrollment/disenrollment are impacted by "medically frail" status as well as overall Medicaid eligibility. *For beneficiaries not impacted by these factors, the individual will be locked-in to the relevant Qualified Health Plan for 12 months*. • Submit a monthly provider file (4275) to the MDHHS enrollment broker for use in assisting beneficiaries with plan selection.	Kathy Stiffler, DHHS
Agreements and Financial Obligations	• Sign a Memorandum of Understanding with MDHHS regarding the Marketplace Option. • Accept financial transactions from MDHHS.	Kathy Stiffler, DHHS
Enrollee Premiums and Cost-Sharing	• Monitor co-payment charges against maximum co-payment amounts and notify applicable Health Care Providers when the beneficiary's maximum cost-sharing obligation has been reached so that no further co-payments are charged. • Issuers will not collect enrollee premiums (enrollee premiums will be collected by an MDHHS-selected vendor).	Kathy Stiffler, DHHS
Data Related Matters	• Make enrollee information available to the Healthy Michigan Plan evaluation contractor as needed. • Make enrollee information available to MDHHS as needed. [NOTE: The scope of the information to be provided is unknown at this time.]	Kathy Stiffler, DHHS

Topic	Issuer Proposed Requirements	Department Contact
Care Transitions	• Honor care transition requirements established by MDHHS.	Kathy Stiffler, DHHS
Enrollee Grievances and Appeals	• Ensure preservation of beneficiary appeal rights to MDHHS when applicable. • Must participate in and accept the results of MDHHS Fair Hearing process. • Right to internal grievance process under the Insurance Code and an external appeal under the Patient's Right to Independent Review Act, separate and distinct from fair hearing rights.	Kathy Stiffler, DHHS & Laurie VanBeelen, DIFS

Please direct any questions regarding this document to the Department contact:

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